

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

### **I. DISPUTE**

1. a. Whether there should be additional reimbursement of \$38,664.44, for dates of service 05/11/01 through 05/20/01.
- b. The request was received on 04/18/02.

### **II. EXHIBITS**

1. Requestor, Exhibit I:
  - a. TWCC 60
  - b. UB-92
  - c. TWCC 62 forms
  - d. Medical Records
  - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit II:
  - a. TWCC 60 and Response to a Request for Dispute Resolution dated 08/15/02
  - b. UB-92
  - c. TWCC 62 forms
  - d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 08/02/02. Per Rule 133.307 (g) (4) or (5), the carrier representative signed for the copy on 08/05/02. The response from the insurance carrier was received in the Division on 08/19/02. Based on 133.307 (i) the insurance carrier's response is timely.
4. Notice of Medical Dispute is reflected as Exhibit III of the Commission's case file.

### **III. PARTIES' POSITIONS**

1. Requestor:

The only response from the Requestor is from the Table of Disputed Services which states: "Claim should have been paid at 75% as bill exceeds 40K."

2. Respondent:

“This dispute concerns reimbursement for DOS 5/11/2001-5/20/2001. Carrier’s position is that the bill has been paid at a fair and reasonable rate, in accordance with TWCC Medical Fee Guidelines, Commission policy, and the Texas Labor Code...The Medical Fee Guidelines require the provider to bill its usual and customary fee. However, the guidelines do not anticipate that the provider will be paid its usual and customary fee, unless it is less than the maximum allowable reimbursement under the guideline. 28 TEX. ADMIN CODE § 134.201, GR VI. There is no applicable MAR in this situation.”

#### IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are those commencing on 05/11/01 through 05/20/01.
2. The Provider billed the Carrier \$51,552.59 for the dates of service 05/11/01 through 05/20/01.
3. The Carrier made a total reimbursement of \$19,713.40 for the dates of service 05/11/01 through 05/20/01.
4. The amount left in dispute is \$38,664.44.

#### V. RATIONALE

Medical Review Division's rationale:

The medical reports indicate that the services were performed. The medical documentation submitted by the Requestor indicates that the total hospital bill was \$51,552.59. Per Rule 134.401 (c)(6) (A)(i)(iii), once the bill has reached the minimum Stop-Loss threshold of \$40,000.00, the entire admission will be paid using the Stop-Loss Reimbursement Factor (SLRF) of 75%. Per Rule 134.401 (c)(6)(A)(v), the charges that may (emphasis added) be deducted from the total bill are those for personal items (television, telephone), those not related to the compensable injury, or if an onsite audit is performed, those charges not documented as rendered during the admission may be deducted.

The carrier is allowed to audit the hospital bill on a per line basis. The Carrier denied “Hospital Services” as M-NO MAR, REDUCED TO FAIR AND REASONABLE RE-EVALUATION NO ADDITIONAL RECOMMENDED ALLOWANCE INVOICE-10%”. The Carrier also reduced the implantables. Per the information submitted by the carrier and the provider, an invoice was submitted with the per/unit cost of the implantables. In reading Rule 134.401 (c)(6), additional reimbursement only (emphasis added) applies if the bill does not reach the stop-loss threshold. The hospital is required to bill, “...usual and customary charges...” per Rule 134.401 (b)(2)(A). The carrier should audit the entire bill to see if the charges represent “usual and customary” amounts. This would include the implantables. Therefore, the carrier would audit the implantables and reduce them to “usual and customary” charges if they thought the bill for implantables

was inflated. (It would not be appropriate to start out the audit by automatically reducing the cost of the implantables to cost + 10%, which is indicated in the Medical Fee Guideline since the rule states this method is used only for the per diem reimbursement methodology.) There was no documentation submitted by the carrier to indicate that the reduction of the implantables was based on anything more than reducing them up front to cost + 10%. There is no documentation to indicate that the carrier attempted to determine the usual and customary charges billed by other facilities for implantables in the same geographical region as the Hospital. Even if the charge appears to be inflated based on the invoice or based on information from the Fee Guidelines, the carrier must determine what is usual and customary for those items in that region and billed by other facilities. If other facilities only bill cost + 10% for implantables, some evidence of that determination would be needed if the Hospital challenges the reimbursement amount. The carrier would also subtract any personal items or items not related to the compensable injury and then determine the final amount to see if the bill would be paid at the per diem methodology or the stop-loss methodology.

The hospital has billed its "usual and customary charge" of \$23,288.00 for the implantables. The carrier has not submitted evidence of what is usual and customary in that region for these items.

Therefore, the total reimbursement will be calculated in the following manner:

Total charges are \$51,552.59.

Multiply the audited charges of \$51,552.59 x 75%

$\$51,552.59 \times .75 = \$38,664.44$

The carrier paid \$19,713.40

$\$38,664.44 - \$19,713.40 = \$18,951.04$

Therefore, additional reimbursement is recommended in the amount of \$18,951.04.

The above Findings and Decision are hereby issued this 12th day of September 2002.

Michael Bucklin, LVN  
Medical Dispute Resolution Officer  
Medical Review Division

MB/mb

## **VI. ORDER**

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit \$18,951.04 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 12th day of September 2002.

David R. Martinez  
Manager Medical Review  
Medical Review Division

DM/mb